Date: [Date]

To: [Dentist Name]
Fax/Address: [Dentist Contact Information]

RE: Medical Clearance for Dental Procedure
Patient Name: [Patient Name]
Date of Birth: [Date of Birth]

Dear Dr. [Dentist Last Name],

The above-referenced patient is currently under my care for the management of [Diagnosis/Condition]. I understand they are scheduled for the following dental procedure: [Description of Procedure].

Current Anticoagulation/Antiplatelet Therapy:
Medication: [Medication Name, e.g., Warfarin, Eliquis, Plavix]
Dosage: [Dosage and Frequency]
Most Recent INR (if applicable): [Value] on [Date]

Medical Recommendation:

[ ] **Continue Medication:** Proceed with the dental procedure without interrupting the medication. Local hemostatic agents should be used as needed.

[ ] **Hold Medication:** Discontinue [Medication Name] for [Number] days prior to the procedure. Resume medication [Number] hours/days after the procedure, provided hemostasis is achieved.

[ ] **Bridge Therapy:** Discontinue [Medication Name] and initiate bridging with [Injectable Anticoagulant Name] as per the attached protocol.

Additional Instructions:
[Specific instructions regarding antibiotic prophylaxis or bleeding management]

If you have any questions or require further clarification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Hematology Practice Name]